Agency:	**107 Health Care Authority**
Decision Package Code/Title:	**ML2-LK Support Health Homes Strategy 1**
Budget Period:	**2015 Supplemental Submittal**
Budget Level:	**ML2 – Maintenance Level**

Recommendation Summary Text

The Health Care Authority (HCA) requests a reduction of $16,486,000 total funds in the 2015 supplemental for the Health Home program. This represents an increase of $1,467,000 GF-State and a reduction of $17,953,000 GF-Federal.

Package Description

Background on the Health Home Model

Under Washington State's approach, the health home program is the bridge to integrate care within existing care systems for high-risk, high-cost adults and children, including dual eligibles. A health home is the central point for directing person-centered care and is accountable for:

- Reducing health care costs, specifically hospital; admissions/readmissions and emergency department visits;
- Providing timely post discharge follow-up; and
- Improving patient outcomes by mobilizing and coordinating primary medical, specialist, behavioral health and long-term care services and supports.

Care Coordinators must be embedded in community based settings to effectively manage the full breadth of beneficiary needs. Washington has four high level goals for the health home program:

- Improve the beneficiary's clinical outcomes;
- Improve the beneficiary's self-management abilities;
- Improve health care quality and promote efficient and evidence-based health care service delivery; and
- Reduce future cost trends or at the very least attain cost neutrality with improved outcomes.

The foundation of the State's health homes is the community network, which must be present in order to qualify as a Health Home. Partnerships across mental health and substance abuse providers, long-term services and supports providers and the medical community are developed to support care coordination and access through integrated health home services. The beneficiary is involved in their improving their health through the development their Health Action Plan. Beneficiaries may choose to include their families and caregivers as part of their health home team.

The Health Home program has been successful in achieving several milestones:

- 3,450 high-risk, high cost beneficiaries have been engaged in health home activities. Evidence based screenings and interventions are being implemented with beneficiaries receiving health home services. In part this strategy was implemented to provide a model of care based on attaining core outcomes, but also to target improved beneficiary self-management and confidence in working with health and social service providers to improve health, reduce cost and improve the quality of care.

- Over 300 Care Coordination Organization staff have received Health Home training, including many who provide services to the highest risk Medicaid and dually eligible beneficiaries.
- The establishment of a network of Health Home Lead Entities and Care Coordination Organizations supports the broad goals established in the State Health Care Innovation Plan including Accountable Communities of Health, Behavioral Health Organizations, and Fully Integrated physical health/behavioral health plans. Community based organizations have new skills in cross systems care coordination because of their involvement in the Health Home program.
- Recruitment and retention of Care Coordination Organizations and Care Coordinators is one of the key elements to providing community based care coordination services. All partners in this program are working collaboratively to establish relationships with non-traditional health and social service providers to deliver person centered care.
- In keeping with the State Health Care Innovation Plan, which includes the prominent role for Community Health Workers, affiliated staff working with Care Coordinators include Community Health Workers (CHWs) and Peer Counselors.

As reported in February, the initial implementation experienced challenges relating to bringing up a new, complex program. At this point, the system issues and technical aspects of enrollment and reporting have largely been resolved. The remaining issues of client outreach and engagement are common to most efforts that involve high-risk low-income beneficiaries. An interim report, scheduled to be completed in October, will outline strategies to address those issues and improve the sustainability of the program.

Questions related to this request should be directed to Christy Vaughn at (360) 725-0468 or at Christy.Vaughn@hca.wa.gov.

Fiscal Detail/Objects of Expenditure

	FY 2015	Total
1. Operating Expenditures:		
Fund 001-1 GF-State	$ 1,467,000	$ 1,467,000
Fund 001-C GF-Federal Medicaid Title XIX	$(17,953,000)	$(17,953,000)
Total	**$(16,486,000)**	**$(16,486,000)**

	FY 2015	Total
2. Staffing:		
Total FTEs	-	-

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	FY 2015	Total
3. Objects of Expenditure:		
A - Salaries And Wages	$ -	$ -
B - Employee Benefits	$ -	$ -
C - Personal Service Contracts	$ -	$ -
E - Goods And Services	$ -	$ -
G - Travel	$ -	$ -
J - Capital Outlays	$ -	$ -
N - Grants, Benefits & Client Services	$(16,486,000)	$(16,486,000)
Other (specify) -	$ -	$ -
Total	**$(16,486,000)**	**$(16,486,000)**

	FY 2015	Total
4. Revenue:		
Fund 001-C GF-Federal Medicaid Title XIX	$(17,953,000)	$(17,953,000)
Total	**$(17,953,000)**	**$(17,953,000)**

Narrative Justification and Impact Statement

What specific performance outcomes does the agency expect?

The Health Home program is the bridge to integrate care within existing care systems for high-risk, high-cost adults and children, including dual eligible clients. A health home is the central point for directing person-centered care and is accountable for:

- Reducing health care costs, specifically hospital; admissions/readmissions and emergency department visits;
- Providing timely post discharge follow-up;
- Improving patient outcomes by mobilizing and coordinating primary medical, specialist, behavioral health and long-term care services and supports; and
- Increase in home and community based placement

Care Coordinators must be embedded in community based settings to effectively manage the full breadth of beneficiary needs. Washington has four high level goals for the health home program:

- Improve the beneficiary's clinical outcomes;
- Improve the beneficiary's self-management abilities;
- Improve health care quality and promote efficient and evidence-based health care service delivery; and
- Reduce future cost trends or at the very least attain cost neutrality with improved outcomes.

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Performance Measure Detail
Activity Inventory
H010 HCA Healthy Options
H012 HCA All Other Clients – Fee for Service – Optional Services

Is this decision package essential to implement a strategy identified in the agency's strategic plan?
Yes. The mission of the HCA is to provide high quality health care for the state's most vulnerable residents. This request is essential to the agency's goal to improve the health of Washingtonians.

Does this decision package provide essential support to one or more of the Governor's Results Washington priorities?
Yes. The Health Home program supports the goal in Results Washington to increase the percentage of clients who report that they have a personal health care provider; also the program supports the goal of controlling the growth of expenditures in Medicaid by focusing on the highest risk beneficiaries.

What are the other important connections or impacts related to this proposal?
The Health Home program supports legislative direction as expressed by bills passed in the 2014 session. For example:

- Under House Bill 2572, Sec. 1: "The legislature declares that collaboration among state purchased health care programs, private health carriers, third-party purchasers, and health care providers to identify appropriate strategies that will increase the quality and effectiveness of health care delivered in Washington state is in the best interest of the public." In Sec. 2: "The state health care innovation plan establishes the following primary drivers of health transformation, each with individual key actions that are necessary to achieve the objective:… (b) Improve chronic illness care through better integration and strengthening of linkages between the health care delivery system and community, particularly for individuals with physical and behavioral comorbidities."
- In SSB 6312, …"contracts issued or renewed on or after January 1, 2015, including: … (H) Established consistent processes to incentivize integration of behavioral health services in the primary care setting, promoting care that is integrated, collaborative, co-located, and preventive.

What alternatives were explored by the agency, and why was this alternative chosen?
Due to the nature of the Health Home program, the agency explored no other alternatives.

What are the consequences of adopting this package?
The cost-effectiveness of the Health Home program relies on achieving cost savings and quality metrics for the dual eligible population. Currently the major risk is not achieving high enough engagement to achieve cost savings at the level required by CMS.

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What is the relationship, if any, to the state capital budget?
None

What changes would be required to existing statutes, rules, or contracts, in to implement the change?
None

Expenditure and Revenue Calculations and Assumptions

Revenue Calculations and Assumptions:
None

Expenditure Calculations and Assumptions:
The projected "valley" that occurs in the 2015-17 biennium has been reduced by approximately $2 million (state funds) from the original projection, due to the lower than expected enrollment in Health Homes.

Which costs, savings, and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?

Distinction between one-time and ongoing costs:
All costs in this decision package are ongoing and would continue as long as the Health Home program continues.

Budget impacts in future biennia:
In future biennia the federal funding percentage decreases as the program shifts from a demonstration to a fully operational program within Medicaid and Medicare.